CLEMSON RURAL HEALTH

MEDICAL SURVEILLANCE PROGRAM ENROLLMENT

Please complete this form in its entirety and submit to ClemsonMSP@clemson.edu. Your enrollment will be processed within 72 business hours and you will be notified via SciShield. Medical Surveillance Enrollment is provided at no cost to the enrollee. By submitting this form, you are consenting to enroll in the Medical Surveillance Program at Clemson Rural Health and your Medical Surveillance Information will be housed in SciShield.

PATIENT INFORMATION

Name *(Last, First, M.I.):*		
Preferred Name or Alias:		
Date of Birth:		**Sex:** ☐ Male ☐ Female ☐ Other ☐ Prefer Not To Disclose
Contact Information:		
Home address:		**Home Phone:**
City:		**Work Phone:**
State:	**Zip Code:**	**Mobile Phone:**
County:	**Country:**	**Email:**

Are you employed at Clemson University? ☐ Y ☐ N	**Are you a student at Clemson University?** ☐ Graduate ☐ Undergraduate
Department:	**Major:**
Occupation:	**Faculty Name:**
Supervisor's Name:	**Course:**

Please proceed to page 2 to complete this enrollment.

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Please select all possibly hazardous exposures in your job/research:

Animals: ☐Aquatic ☐Birds ☐Farm ☐Insect ☐Lab ☐Wild

Animal Populations:

Human/Primate: ☐Blood ☐Blood product

Environmental: ☐Chemicals ☐Dust ☐Noise

☐Other:

☐Yes	☐No	I will be exposed to animal populations that may carry rabies.
☐Yes	☐No	I will be involved in recombinant DNA technology, Human Gene Transfer, or Xenotransplantation.
☐Yes	☐No	(For women only): I am pregnant or planning to become pregnant within the next year.

Medical History (mark all that apply): ☐ I have no significant medical history

☐ Anemia	☐ Arthritis	☐Cancer	☐Diabetes
☐Difficulty Smelling	☐Dizziness or Fainting	☐Hearing Problems	☐Heart Problems
☐Heat Stroke	☐High Blood Pressure	☐Joint or Muscle Problems	☐Kidney or Liver Disease
☐Rheumatic/Scarlet Fever	☐Seizures/Epilepsy	☐Stomach/Bowel Problems	☐Tuberculosis
☐Vision Problems	☐Other:		

☐Yes ☐No I have a medical condition or take medications/treatments that impair my immune system (such as HIV, cortisone, chemotherapy, radiation).

☐Yes ☐No I have a pre-existing cardiac valvular disease or have a vascular graft.

Please list all current medications:

_____

_____

Allergy History:

Do you have or have you had any of the following diseases or conditions?

			When	Explanation
☐Yes	☐No	Asthma/Wheezing		
☐Yes	☐No	Chronic Cough/Bronchitis		
☐Yes	☐No	Eczema/Skin Rash		
☐Yes	☐No	Hay Fever/Seasonal Allergies		
☐Yes	☐No	Itchy, irritated eyes		
☐Yes	☐No	Shortness of Breath		
☐Yes	☐No	Other lung/breathing problems		
☐Yes	☐No	Allergies to food or medicines (list):		
☐Yes	☐No	Allergies to pollen, grass, weeds, trees, yeast or mold (list):		
☐Yes	☐No	Allergies to latex, chemicals, or other substances (list):		
☐Yes	☐No	Allergies to animals (list):		

Immunization History (Please include a copy of your immunization record with your submission).

Year	Year	Year
Teatanus/Td:	Tdap:	Hepatitis B (date of series completion):
Rabies:	TB test:	

By signing this document, I certify that the health information provided is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

Print Name: _____ Date:

FOR OFFICE USE ONLY

Date Reviewed: _____ Signature of Reviewer: _____